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# Suicidality and Self-Harm Among Sexual Minorities in Japan

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In this study, I used ethnographic methods to examine suicidality and nonsuicidal self-harm among gay, lesbian, bisexual, and transgender persons in Japan. Participants ( $N = 84$ ) indicated that suicidality and self-harm are serious problems among sexual minorities and tend to be driven by (a) a homophobic/transphobic environment and the negative consequences of sexual minorities either disclosing their true selves or remaining hidden and silent within such an environment; (b) various antecedents to poor mental health; and (c) factors not directly related to being a sexual minority, particularly unemployment and debt in the context of a protracted national economic decline in Japan prior to the study period of 2003–2004. Participants also perceived a potentially higher risk for suicidality and self-harm among sexual minority adolescents and persons in their early 20s; those who work in the entertainment, bar, or sex industries; and survivors of violence perpetrated by intimate partners or family members.

**Keywords:** *Asia; bisexuals; ethnography; gays and lesbians; Japan, Japanese; minorities; qualitative methods, general; sexuality; transsexuals; violence; vulnerable populations*

Scholars continue to debate whether Japanese society is more accepting or rejecting of gay, lesbian, bisexual, and transgender persons (i.e., sexual minorities) compared to other societies. The historical and social science literatures, however, are fairly clear on one point: Compared to its own past, modern Japan is not as accepting of sexual minorities. Indeed, there has been a radical transition in attitudes regarding homosexuality and transgender identity in the past 125 years in Japan from relative tolerance, particularly for males, to notions of illegitimacy and abnormality (Furukawa, 1995; Hawkins, 2000; Leupp, 1995; McLelland, 2004). This shift in social norms started during the Meiji Restoration (1868–1912) and was due largely to the influence of the dominant medical and psychological discourses of England and Europe from the 1910s through the 1930s, particularly those of the new science, sexology, which was increasingly influential in Japan during this period (Chalmers, 2001; Herdt, 1997). Same-sex desire and cross-gender role presentation were subsequently reframed as physiological or psychiatric illnesses. Only quite recently (1994), the Japanese Society of Psychiatry and Neurology changed its official stance on homosexuality, no longer classifying it as a paraphilic disease (International Gay and Lesbian Human Rights Commission, 1995). Nevertheless, transgender

persons still contend with the dominant medical model of gender dysphoria (i.e., gender identity disorder; Kameya & Narita, 2000; McLelland, 2004), and all sexual minority subgroups in Japan continue to experience the legacy of medicalization and pathologization. Contemporary mainstream Japanese society typically perceives and represents sexual minorities as abnormal, dismisses them as comic relief, or fails to recognize them at all (Fushimi, 1994; Valentine, 1997).

Within this stigmatizing sociocultural context, sexual minorities in Japan are subject to discrimination (DiStefano, 2006a; Hidaka & Operario, 2006), and they experience and perpetrate several forms of violence. Physical, psychological, verbal, and sexual assaults perpetrated by other persons occur publicly, motivated by victims' sexual orientation or gender identity (i.e., bashing), and occur privately within intimate partner dyads and at the hands of family members (DiStefano, 2006b, in press; Hidaka, 2001a, 2004; Hidaka & Operario, 2006). However, little is known about violent behavior among sexual minorities that is directed at the self.

The World Health Organization (WHO) includes in its definition of violence the intentional use of force or power against oneself that "either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation"

(Krug, Mercy, Dahlberg, & Zwi, 2002). Thus, both suicidality<sup>1</sup> and nonsuicidal self-harm among sexual minorities in Japan are considered here under the WHO's classification of self-directed violence (Krug et al., 2002).

The small amount of current knowledge regarding sexual minority suicidality and self-harm (SMSS) in Japan is based on limited quantitative data. An early study of the relatively rare phenomenon of double suicide in Japan by Ohara (1963) found that 4% of the cases were among lesbians and gay men. To the author's knowledge, there are no other studies that disaggregate sexual minorities from the general population in Japan in terms of fatal (i.e., completed) suicide. However, in studies on separate samples, Hidaka (2001b; Hidaka & Operario, 2006) found high lifetime prevalence of suicidal thoughts and suicide attempts among Japanese men who identified as gay, bisexual, or questioning of their sexual orientation (GBQ). In one study ( $N = 160$ ), 54% of the GBQ men had thought about committing suicide and 16% had made actual attempts (Hidaka, 2001b). In the other study ( $N = 1,025$ ), 64% had thought of killing themselves, whereas 15% reported a history of attempted suicide (Hidaka & Operario, 2006). Neither study included a heterosexual comparison group, and it is still unknown whether any sexual minority subgroup in Japan has a higher prevalence of suicidal ideation (i.e., thoughts, plans) or a higher incidence of suicide attempts, compared to the general population.

Japanese research on suicidality has focused on fatal suicides, and the comparatively small literature on suicidal ideation and suicide attempts has focused on the elderly (Ono et al., 2001), terminally ill (Akechi, Okamura, Nishiwaki, & Uchitomi, 2002), and mentally ill (Nakao, Yamanaka, & Kuboki, 2002)—not the general population. We do know that Japan has a high incidence of fatal suicide in the general population: 25.1 per 100,000 in 2004 (35.6 per 100,000 for men; 12.8 per 100,000 for women), which ranks ninth globally and is the highest rate, both overall and for men, among developed, high-income countries (Nakao & Takeuchi, 2006; WHO, 2007). The highest suicide rate for females in Japan in 2004 was among women aged 75 years and older, which is consistent with the trend in other countries, as the overall suicide rate is highest in this age group, globally (WHO, 2000, 2004). The highest rate among males in Japan, however, was in a slightly younger group: men aged 55–64. Suicide was the sixth leading

cause of death in Japan in 2004, overall, and the leading cause of death among males aged 15 to 49 years and females aged 10 to 34 years (Ministry of Health Labor and Welfare, 2004; WHO, 2006; Yamamura, Kinoshita, Nishiguchi, & Hishida, 2006). Since 1998, there have been approximately 30,000 suicides per year, with a peak of 34,427 in 2003—the highest number ever recorded in Japan (Inoue et al., 2007). There were 29,887 suicides in 2006 (Ministry of Internal Affairs and Communications, 2006).

Several possible explanations for the relatively high suicide rate in Japan have been proposed. First, there is a long history of cultural acceptance of suicide. For example, the ritualistic suicide (*seppuku*) of the samurai class provides a cultural precedent for suicide as a rational, even morally virtuous act (Young, 2002). Suicide in modern Japan might retain moral overtones in some cases, particularly if the act fulfills one's duty to others in a collectivist culture that is based in the Confucian principle that self-sacrifice is a virtue (Young, 2002). Second, a number of studies have indicated that economic troubles, including unemployment and other financial and career difficulties, are associated with the high rate of suicide, especially after 1998, and are probably connected to the national economic decline that began in the early 1990s (Inoue et al., 2007; Nakao & Takeuchi, 2006; National Police Agency, 2003; Takei, Kawai, & Mori, 2000). Third, the rapid aging of Japan's population could partly be driving the high suicide rate, as suicide incidence is highest among persons aged 55 and older. Depression, lack of social support, impaired instrumental activities of daily living, and alcohol-related disorders were found to be associated with suicidal ideation among urban Japanese elderly (Awata et al., 2005). Depression, other physical and mental illness, and family problems, which are factors commonly cited as driving suicidality in Japan across demographic groups in the general population, do not seem to be particularly unique to the country (Kuwabara et al., 2006; National Police Agency, 2003).

No studies in Japan have examined nonsuicidal self-harm specifically among sexual minorities. Nishizono and Yasuoka (1979) introduced Rosenthal, Rinzler, Walsh, and Klausner's (1972) concept of "wrist-cutting syndrome" to Japan in 1979. Since then, most research on nonsuicidal, often habitual, self-harm has used clinical samples (e.g., Matsumoto, Azekawa, Yamaguchi, Asami, & Iseki, 2004), but a recent population-based study (Yamaguchi, Matsumoto, Odawara, & Takeuchi, 2004) found that

7% of Japanese university students had injured themselves at least once by various methods, including self-cutting and self-burning. Another study (Izutsu et al., 2006) surveyed junior high school students in Kanagawa Prefecture and found that 8% of males and 9% of females reported self-cutting, whereas 28% of males and 12% of females reported self-hitting.

It is challenging to place the prevalence of nonsuicidal self-harm in Japan in an international context due to the scarcity of truly comparable data from multiple countries. Most international data on deliberate self-harm are, in fact, on fatal suicides, and to a lesser extent attempted suicides. Nevertheless, based on available research that focuses largely on adolescents and young adults, it does not appear that Japan is necessarily worse off with regard to self-harm than several other countries. Studies conducted in England, the United States, and Australia indicate that 5% to 9% of adolescents in those countries reported having self-harmed in the previous year, with few cases appearing to be actual suicide attempts (Grunbaum et al., 2004; Hawton, Rodham, Evans, & Weatherall, 2002; G. Patton et al., 1997). In addition, what Skegg (2005) terms "superficial self-mutilation" seems to be highly prevalent among young people internationally: one fifth of Turkish high school students, one third of Canadian female undergraduates, and one third of undergraduate psychology students in Massachusetts reported such behaviors (Gratz, 2001; Paivio & McCulloch, 2004; Zoroglu et al., 2003).

Most current knowledge regarding SMSS comes from research outside Japan. These studies have shown that self-harm and suicidal behaviors are highly prevalent among same-sex-attracted and transgender persons (Clements-Nolle, Marx, & Katz, 2006; Ortiz-Hernández & García Torres, 2005)—particularly youth, who receive special attention in the literature (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999). Most studies on this topic have found significantly higher prevalence or risk of suicidality and self-harm among sexual minorities compared to heterosexuals and persons with normative gender identities (e.g., Cochran & Mays, 2000; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003). As in Japan, no international studies have yet examined whether sexual minorities have higher rates of fatal suicide compared to the general population, but there are indications from medical examiners' reports on male suicides that this might be the case (Bagley, 1992).

The present study had two main purposes: (a) to add to the small amount of existing knowledge

regarding suicidality among sexual minorities in Japan by examining, in addition to GBQ men, other sexual minority subgroups that previously have not been included in studies of this topic and (b) to investigate nonsuicidal self-harm for the first time among sexual minorities. In so doing, ethnographic methods were used to document specific reports of SMSS, to begin to understand why SMSS is occurring in Japan, and to identify specific areas of inquiry that subsequent studies can examine further.

## Method

Findings on SMSS reported here are derived from analyses of data collected in a larger ethnographic study of general violence involving sexual minorities in Japan (DiStefano, 2006b, in press).

### Data Collection

Ethnographic methods (Spradley, 1979, 1980) were used to collect data in Japan between October 2003 and May 2004. Formal, in-depth, qualitative interviews ( $n = 39$ ) were combined with participant observation, which included informal interviews ( $n = 54$ ). Nine persons participated in both the formal qualitative interviews and the informal interviews during participant observation, yielding a combined, unduplicated sample of 84 individuals ( $N = 84$ ). Participant recruitment continued until preliminary analyses, concurrent with data collection, indicated saturation of the data with regard to emergent themes.

*Qualitative interviews.* The qualitative interviews were formal, scheduled in advance, and followed a semistructured interview guide. Thirty-one of the 39 interviews were conducted in Tokyo, and the remaining 8 were conducted in Kyoto, Nagoya, Chiba, and Ibaraki. To ensure the acquisition of data on the fullest range of experiences and perceptions possible, the study sought to document reports of self-directed violence at three socioculturally meaningful levels of analysis in the Japanese context (Bachnik & Quinn, 1994): (a) personal experience (self, *jibun*); (b) specific SMSS incidents within one's circle of family, friends, intimate partners, coworkers, clients, and acquaintances (in-group, *uchi*); and (c) cases of SMSS experienced outside this same group (out-group, *soto*), such as third parties more distally positioned in social networks or reports in sexual minority media. Rather than discounting reports of SMSS experienced by other persons as merely

**Table 1**  
**Selected Demographics of Study**  
**Participants (N = 84)**

	No. of participants
Qualitative interview sample (n = 39)	
<i>Sex/gender identity</i>	
Male	23
Female	10
Transgender, Male-to-female (MTF)	1
Transgender, Female-to-male (FTM)	4
Intersex	1
<i>Sexual orientation</i>	
Gay	22
Lesbian	6
Bisexual	3
Pansexual ("open to all")	1
Heterosexual	1
Questioning/uncomfortable with labels	5
Refused to state	1
Age (Mean = 32.6 years)	
20–29	16
30–39	13
40–49	8
50–59	2
<i>Employment status<sup>a</sup></i>	
Full time	22
Part-time	5
Student	11
Unemployed	2
<i>Marital status</i>	
Currently married (heterosexual spouse)	1
Divorced (heterosexual spouse)	4
Never married	34
Participant observation sample (n = 54)	
<i>Sex/gender identification</i>	
Male	35
Female	19
<i>Sexual orientation</i>	
Gay	25
Lesbian	6
Bisexual	1
Pansexual	1
Heterosexual	21

a. Totals to more than 39 because multiple responses possible.

hearsay, it was essential to trust respondents' richly detailed accounts and accept them as viable data. Due to the pervasive silence around violence involving sexual minorities in Japan, including suicidality and self-harm, it was critical to document all relevant reports and perceptions at this early stage of research on the topic. Personal names and identifying information were removed from data records to maintain confidentiality, and only gender-appropriate pseudonyms are used in this article.

*Participant observation.* Participant observation included personal interaction with community members; participation in community activities; observations; and informal, unscheduled interviews with participants, mainly in sexual minority community settings (e.g., bars, clubs, parks, personal residences, social gatherings, community events) and occasionally in "mainstream" settings (e.g., trains, universities, offices). Most fieldwork occurred in Tokyo, particularly in Shinjuku Ni-Chome, the main sexual minority community in the city where the author was based during the study period. Additional fieldwork was conducted in Kyoto, Nagoya, Chiba, and Ibaraki. All participant observation activities, including quotes from informal interviews and observations of behavior, were recorded in field notes, which were then formally analyzed.

## Participants

*Qualitative interview participants.* For the formal qualitative interviews, snowball sampling, a useful method in research on difficult-to-access populations (Bernard, 2002), was used to recruit adults (age 20 or older)<sup>2</sup> who self-identified as a sexual minority (n = 26). This involved locating a few key individuals and asking each of them to refer other people in their social networks to the study, then repeating this procedure with each new participant. In addition, purposive sampling (M. Patton, 2002) was used to identify key informants, or experts (n = 13), who, by means of their professional experience, possessed specific, insider knowledge and insight relevant to SMSS in areas such as medical care, mental health, law, academic research, violence prevention, and social services, including services provided by nongovernmental organizations targeting sexual minority clients. Although the original sampling strategy did not include recruitment of intersex<sup>3</sup> participants, one intersex person learned of the study through his social network and became a participant. In addition, whereas sexual minority identity was not an inclusion criterion for experts, 10 of the 13 expert participants did self-identify as sexual minorities. Selected demographic characteristics of participants in the qualitative interviews are summarized in Table 1.

*Participant observation.* Snowball sampling was used also in participant observation to access and benefit from existing social networks. Sexual minority identity was not a criterion for inclusion in this component of the study. Indeed, perceptions and knowledge of SMSS held by heterosexually identified, gender-normative persons were valuable in supplementing the data from sexual minority participants,



thus allowing for a more contextualized and complete understanding of the problem. The participant observation sample included 54 adults aged 20 or older. Due to the comparatively informal interviewing style used in participant observation fieldwork in this study, the collection of demographic data was limited to gender identification and sexual orientation (see Table 1).

## Data Analysis

According to participant preference, 32 formal qualitative interviews and 41 informal interviews during participant observation were conducted by the author in Japanese, and 7 formal qualitative interviews and 13 informal interviews during participant observation were conducted in English, or a mix of English and Japanese. All audio-recorded formal interviews were transcribed verbatim without translation and, together with participant observation field notes, were inductively coded in the original language using ATLAS.ti 5.0 (Scientific Software Development, 2005). The coded data were analyzed for emergent themes and conceptual connections by applying techniques used in grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990) and the systematic, iterative approach to qualitative text analysis outlined by Willms et al. (1990). Questions regarding nuanced language and meaning were addressed to Japanese research assistants for confirmation throughout the analysis.

## Findings

Five major themes emerged from analysis of data from the qualitative interviews and participant observation: fatal and attempted suicide; thoughts and plans of suicide; nonsuicidal self-harm; groups perceived to be at higher risk; and reporting and help seeking. Participants reported self-directed violence at each of the three sociocultural levels of analysis examined in the study: self, in-group, and out-group.

### Fatal and Attempted Suicide

Several participants in the study described fatal and attempted suicides by persons in their in-group who identified as sexual minorities. For example, among the 39 participants in the formal qualitative interviews, there were 18 reports of fatal suicides committed by sexual minority friends, intimate partners, and acquaintances. Two of the reported cases were lesbian couple suicides, in which both partners

killed themselves at the same time. In addition, two sexual minority study participants reported personal suicide attempts.

*Connection with poor mental health.* Unbalanced or poor mental health in the forms of mental illness, emotional fatigue, psychological pain, and low self-esteem were mentioned by participants in association with suicidality. In this context, depression, post-traumatic stress disorder (PTSD), dissociative identity disorder, gender identity disorder (GID), and nonspecific “neuroses” were emphasized. For example, Chiaki, a 32-year-old male-to-female (MTF) transgender person, explained how she had attempted suicide twice: once at age 19 and again at 29. She sought help from a psychiatrist from age 23 to 27 and was diagnosed with dissociative identity disorder, more commonly known as multiple personality disorder—a condition that Japanese psychiatrists historically, and controversially, have used to diagnose transgender identity. Chiaki believed that GID, which is the more common “diagnosis” given to transgender persons in Japan today (Kameya & Narita, 2000; McLelland, 2004), more accurately captured her condition than dissociative identity disorder. The other participant who reported attempted suicide was Fujiko, who stated that she had tried to kill herself “a few times.” She cited several reasons, including sexual abuse by her father from early childhood to age 17, being abducted by a man she did not know, drug use, sex addiction, having no emotional support when she was a student who was grappling with her sexuality, and having no sexual minority role models. Fujiko, 36, described herself as “pansexual,” meaning that she was open to different sexual orientations and gender identities in her sexual partners. At the time of the interview, she had been receiving care from mental health providers for 7 years, and she had been diagnosed with PTSD secondary to her abduction and repeated sexual abuse.

Both Chiaki and Fujiko reported diagnoses of mental illness, but it was not clear in either person’s case whether actual clinical onset of mental illness preceded or followed their suicide attempts. However, several other participants were quite clear in their ideas about why sexual minorities attempted suicide and how it was connected to mental illness. Namito, a 28-year-old gay man, described a very straightforward chain of events that was typical of this understanding among participants: To be a sexual minority is to feel incredible stress and pressure, which causes mental health to become unbalanced, leading to suicide attempts in many cases.

*Reasons for suicide attempts.* When asked why she tried to kill herself, Chiaki characterized the feelings of many study participants about being a sexual minority in Japan when she replied, “Because life is hard.” Other participants noted a number of more specific reasons why sexual minorities attempted or completed suicide, some related to their sexuality and others seemingly unrelated. These reasons included being confused about one’s sexuality or having difficulty accepting it; not being able to disclose one’s sexuality (i.e., “come out”) to key members of one’s social in-group, particularly to family members and in the workplace, without fear of severe, negative consequences; parents disowning their children upon discovering their sexual orientation; having one’s sexuality intentionally exposed without permission in the workplace (i.e., being “outed”) and the bullying, isolation, and verbal abuse that results; trouble with intimate partners, including separation and cheating; working or other involvement in the entertainment, bar, or sex industries—the so-called *mizu-shoubai* (literally “the water trade”); lack of success in finding a job; business debt; pressure to pass university entrance exams; and caring for elderly family members.

## Thoughts and Plans of Suicide

*During adolescence.* Six participants reported that although they had not actually attempted suicide, they had given serious thought to killing themselves, even to the point of planning the specific method. These thoughts and plans often occurred during adolescence. For example, Tadaaki, a 22-year-old male who still questioned his sexuality but stated that he “likes guys,” reported that during his first year in high school he placed a large amount of pressure on himself to be heterosexual—that is, to resist his homosexual tendencies. He explained that compared to the anguish he was enduring as an adolescent dealing with his sexuality, he thought “it would be better to die,” so that he could “be comfortable and relax.” Similarly, Emiho, a 45-year-old bisexual woman, recounted how her mother used to chastise her for being too boyish. She internalized this sentiment, felt bad about not being feminine enough, and considered suicide several times in her teens. In addition, Araki, a 30-year-old female-to-male (FTM) transgender person who counseled callers on an HIV hotline, reported that he had received many calls from adolescent sexual minorities who confided in him that they were thinking about or planning suicide.

*In adulthood.* Other participants explained that suicidal thoughts and plans sometimes occurred later in life, corresponding to a crisis related to sexual or

gender identity in adulthood. For example, Yamahiko, a 40-year-old FTM, reported that he came out at age 36, at which time he was verbally abused by his father and often considered jumping from the 11th floor of his apartment building. Notably, it was typical for transgender study participants to switch gender presentations, start taking hormones, have a sex change operation, or otherwise deal with their gender identity in their mid- to late 20s or 30s, rather than in their teens and early 20s, which was when most gay/bisexual men and lesbians/bisexual women dealt with many of their acute sexuality issues. Another example was provided by Uchito, who was 39 at the time of our interview and had learned definitively only a year before that he was intersex. At age 38, he experienced menarche, his first menstrual period. Until that time, he had lived his entire life as a man because his mother’s obstetrician had assigned him male gender at birth. When he had his first period and consulted his current physician, he was told, “You might be a woman.” Uchito reported that he was very shocked at this news and seriously considered taking sleeping pills or cutting his wrists to kill himself at the time.

## Nonsuicidal Self-Harm

The data suggest that self-harm without the goal of killing oneself is at least as serious and impactful a problem as suicidality among sexual minorities in Japan, and that many of the same factors drive both sets of behaviors. Participants described various acts committed by themselves or by persons in their in-group as forms of self-harm, including burning oneself; pouring gasoline on oneself but not igniting it; hanging oneself but not for suicide or pleasure (i.e., not autoerotic asphyxia); breaking glasses, cups, and other objects on one’s head, fists, and body; striking one’s head against walls; excessive drinking and drug use; eating disorders; harmful sexual behaviors; and joining the *yakuza* (organized crime syndicates) or violent youth street gangs (*bosozoku*) in order to purposely “drop out of life and society.” However, by far the most commonly reported form of self-harm was cutting, usually on the wrists or other areas of the arms.

Four participants disclosed that they had engaged in self-cutting and shared their experiences. Hamako, a 20-year-old lesbian, reported that she had fallen in love with a heterosexual girl who rejected her, so she cut her own left wrist to deal with the resulting emotional pain. She also indicated separate scars on her left forearm from when she had cut herself during high school because of pressure to excel academically and pass her university entrance exams. Other

participants described cases of self-harm in their in-group. For instance, Wataru, a 29-year-old man who reported his sexuality as “not decided,” recounted how his gay male friend used to cut his own wrists during high school because of the bullying that he experienced at the time.

Kabuto, a 33-year-old gay male mental health counselor whose clients were largely gay and bisexual men, believed there were two major factors that led to self-harm behaviors in his client population: (a) fatigue from constantly having to hide one’s true sexuality and act “straight,” rarely being able to be oneself, and (b) a poor relationship with one’s family. Several factors that were viewed as driving forces of suicidality were reported also as reasons for nonfatal self-harm, including questioning one’s sexuality; wanting to escape the reality of living as a sexual minority and all the difficulties associated with it; despair about transgender identity before learning about how to have a sex change operation; and being involved, or desiring romantic relationships, with straight, gender-normative people—and usually being rejected. Other factors cited as driving self-harm were a history of sexual abuse, low self-esteem, and the enforcement of traditional gender roles and stereotypes.

If death was not the goal of sexual minority cutters, the obvious question arose as to why they would choose to harm their bodies in such a way. In response, a common explanation offered by participants was that cutting “feels safe” and is “something I can control.” Participants explained that although this might sound counterintuitive, it made sense if one considered how much psychological pain many sexual minorities endure in Japan. Such psychological pain cannot be controlled; it ultimately comes from other people, the larger society—sources external to the self. But small cuts on the arms, self-administered carefully so as not to sever any major blood vessels, allow cutters a sense of control over the time, location, duration, and severity of their pain. On the other hand, Yamahiko reported that some of his FTM friends habitually cut their wrists and could not stop the behavior, “similar to an addiction.” This suggested that some sexual minority cutters could not, in fact, control their self-harm.

*Connection with poor mental health.* Participants viewed depression and nonspecific neuroses as connected to self-harm behaviors, similar to their assessment of suicidality. For example, Ikuko facilitated a support group once a month for women who had same-sex attraction tendencies but still questioned

their sexuality. She estimated that about half of the women who had passed through her group over the years were depressed, and that these same women often engaged in wrist cutting and other forms of self-harm.

In addition, while discussing self-harm and its connection to mental illness, some participants reported personal experience of a condition called *hikikomori* and specific cases of this condition among sexual minority members of their in-group. Hikikomori, generally defined as a form of acute social withdrawal (Sakamoto, Martin, Kumano, Kuboki, & Al-Adawi, 2005), was described by participants as occurring when persons did not leave home—or in the case of adolescents, their room—for extended periods of time, effectively cutting themselves off from society and in many cases minimizing contact even with members of their immediate family. Of interest, some participants perceived problems associated with poor mental health, such as hikikomori, as actual forms of self-harm. In other words, these participants described the psychological pain associated with mental illness, or of isolating oneself away from society, as actual means used by some sexual minorities to hurt themselves. The extent to which personal volition was at the root of conditions such as hikikomori in such cases, however, was not clear.

### Groups Perceived To Be at Higher Risk

Suicidality and self-harm were reported for sexual minorities in a variety of age groups and with various professions and life experiences; however, the data indicate that three major groups were perceived to be at potentially higher risk: (a) adolescents and people in their early 20s (i.e., youth); (b) people who work in the entertainment, bar, or sex industries (*mizu-shoubai*); and (c) survivors of violence perpetrated by intimate partners or by family members. Participants reported having experienced physical, sexual, psychological, and verbal violence by intimate partners, family members (i.e., usually parents against their sexual minority children), colleagues at work, other members of their social in-group, and persons in their out-group, secondary to the perpetrators’ knowledge of the victims’ sexual identity. No specific sexual minority subgroup (i.e., gay male vs. lesbian vs. transgender) was perceived to be at higher risk than any other.

### Reporting and Help Seeking

Four participants sought help from mental health providers for self-harm or suicidal thoughts and attempts: three went to psychiatrists and one consulted



a school counselor during high school. Overall, however, participants' narratives suggest that neither reporting of thoughts and behaviors nor seeking professional help is common among sexual minorities who are suicidal or who engage in self-harm. By means of explanation, participants cited a very conservative health care industry, inclusive of medical and counseling services, that made them uncomfortable seeking care. This conservatism was described as an unequivocal atmosphere of homophobia and transphobia, deriving from providers' attitudes, questions, comments, and behaviors during clinical encounters. Thus, even in the relatively rare cases when care was sought, sexual minority participants stated that they simply could not discuss issues related to their sexuality with most providers.

## Discussion

It is significant that several participants in the study perceived a direct connection between suicidality or self-harm and poor mental health, particularly mental illness. This link is not necessarily assumed in Japanese society outside the realms of psychiatry and law. As noted in this article's introduction, suicide, in particular, might also be viewed as a morally logical, and even positive, act within the Japanese sociocultural and historical context (Young, 2002). Indeed, dominant collectivist cultural values in Japan (e.g., Markus & Kitayama, 1991) do not necessarily preclude suicide being rational. As an expression of self-sacrifice, or a method of taking social responsibility for one's acts and fulfilling one's duty to others, suicide can also be understood to resonate with collectivism, which is characterized by the interdependent self, defined in terms of relationships and conceived of as fundamentally embedded in, and not separate from, the larger social context (Gelfand & Dyer, 2000). Most participants in this study, however, maintained that SMSS was the proximal result of unbalanced or poor mental health in the forms of mental illness, emotional fatigue, psychological pain, or low self-esteem. These assessments of SMSS might indicate the growing influence of Japanese psychiatry and law, which have adopted the Western medical tradition of viewing suicide as a nonrational expression of mental illness. This could have positive implications for prevention efforts currently implemented by the Japanese government, including a goal to reduce annual suicide incidence by 27% by 2010 (Yamashita

et al., 2005). However, an overly narrow focus on this medicalized conceptualization of self-directed violence might overlook the effects of the enduring cultural values, beliefs, and social-structural factors that also appear to be driving SMSS both connected with and independent of the mental states of individuals.

A particularly interesting finding regarding the self-harm–mental illness connection was the perception of some participants that hikikomori, or acute social withdrawal, could be an actual form of self-harm. Conventional wisdom with respect to the link between mental illness and self-harm would typically maintain mental illness as a cause of self-harm. As such, the logic of hikikomori's classification in some cases as a form of self-harm was surprising. Further complicating the issue is the fact that hikikomori has been only partly medicalized, characterized in other studies alternately as a "silent epidemic in Japan" (Sakamoto et al., 2005) and as a social problem describing problematic behaviors that might subsume various psychiatric diseases (Suwa, Suzuki, Hara, Watanabe, & Takahashi, 2003).

Participants cited several reasons for the occurrence of SMSS that were directly connected with being a sexual minority. These reasons clustered around the presence of a homophobic and transphobic environment and the negative consequences of sexual minorities either disclosing their true selves or remaining hidden and silent within such an environment. Participants perceived that whichever of these two options were chosen, potential sequelae could drive a sexual minority person toward suicidality or self-harm.

The most commonly mentioned negative consequence of disclosure, or being involuntarily outed, was experience of verbal, psychological, sexual, or physical violence, including bullying and ostracism from the family, workplace, or other social in-group, and violence from strangers in participants' social out-groups. Such abuse was viewed as a major contributor to sexual minority–related stress and poor mental health. This corroborates findings among Japanese GBQ men of associations between attempted suicide and having disclosed sexual orientation to parents, having disclosed to six or more friends, having ever been bullied at school owing to being perceived as homosexual, and having ever been verbally harassed (Hidaka & Operario, 2006). The findings of the current analysis support Hidaka and Operario's (2006) suggestion that among Japanese GBQ men, being more open about sexual orientation

can result in increased levels of stigma and discrimination, thereby heightening the potential for psychological adversity and suicide. The present study suggests that this is probably true also for other sexual minority subgroups in Japan and extends to non-suicidal self-harm in addition to suicidality. Research from outside Japan also has shown that the period of greatest risk for suicidality among sexual minorities surrounds disclosure of sexual orientation to others (D'Augelli, Hersherberger, & Pilkington, 2001), especially one's immediate family (Igartua, Gill, & Montoro, 2003), that those who disclose report verbal and physical abuse by family members, and that harassment and violence victimization predict suicidality among sexual minorities (Garofalo et al., 1999; Huebner, Rebhook, & Kegeles, 2004).

On the other hand, if sexual minorities in Japan choose to protect themselves from violence and stigmatization by not disclosing, this study's data suggest that this suppression of their true selves and prolonged efforts at passing for straight create stress that takes a serious toll on mental health. There is ample accumulated evidence outside Japan that "coming out" and association with affirmative sexual minority networks is correlated with positive psychological adjustment, particularly with respect to self-esteem (e.g., Jacobs & Tedford, 1980). The degree to which such findings apply to sexual minorities in Japan, however, must be investigated further.

Participants also gave other reasons for SMSS that appeared unrelated to being a sexual minority specifically. These factors seemed to be driving people toward suicidality and self-harm not as sexual minorities, *per se*, but simply as members of the larger Japanese society, subject to the same forces as the general population in which they are embedded. The burden of caring for elderly family members in Japan's rapidly aging society and pressure to excel academically during youth are good examples cited by participants. Perhaps chief among these factors were unemployment and debt, which were mentioned frequently by participants as reasons for SMSS and are best understood in the context of the protracted national economic decline in Japan that began in 1990. Much of the Japanese suicide literature has focused on the association between the economic decline and rising suicide rates (e.g., Aihara & Iki, 2003). For example, Inoue et al. (2007) found that suicide rates correlated significantly with unemployment rates between 1978 and 2004.

In 1998, the number of suicides in Japan increased dramatically to 32,863, and the number has remained at approximately 30,000 per year since then, compared to an average of 22,000 suicides per year from 1988 to 1997. It appears that there was an 8-year lag between the burst of Japan's "bubble economy" in 1990 (e.g., Hamada, 2004) and the sharp increase in the number of suicides in 1998. The economy started recovering gradually in 2002, just months before the period of this study (Takahara, 2007), and it continues to grow (Terada, 2007). Thus, it is possible that Japan is currently in the midst of a parallel lag to an opposite trend such that as the economy continues to improve and the lag ends, there might be a significant decrease in the number of suicides, including those committed by sexual minorities. No clear trend of such a change is yet apparent, however, as both the absolute number of suicides per year and the rate per 100,000 have continued minor up-and-down oscillations since 1998 without significant declines (Inoue et al., 2007; Nakaya et al., 2007).

There was a perception among participants in the present study that youth; persons employed in the entertainment, bar, or sex industries; and persons with a history of victimization might be at increased risk of SMSS. As stated previously, the latter result supports Hidaka and Operario's (2006) findings of an association between attempted suicide and experience of bullying and verbal harassment among Japanese GBQ men; however, age was not a significant predictor in their study, nor was field of employment. Future research should test hypotheses of associations between SMSS and other forms of victimization, age group, and field of employment. We do know that recent studies of nonfatal self-harm in the general Japanese population have focused attention on this problem among youth (e.g., Izutsu et al., 2006), and suicide was the leading cause of death among adolescents in the general population in 2004 (Ministry of Health Labor and Welfare, 2004; WHO, 2006; Yamamura et al., 2006). In addition, there is evidence from the United States that suicide risk is clustered earlier in life for gay and bisexual males (Paul et al., 2002) and transgender persons (Clements-Nolle et al., 2006). However, the present study also documented reports of suicidality and self-harm occurring later in adulthood. Clearly, sexual minority-related stress, proposed here as a concept incorporating both minority stress (Meyer, 1995) and gay-related stress (Rotheram-Borus, Hunter, & Rosario, 1994), does not necessarily pass with adolescence.

As to field of employment, a number of studies outside Japan suggest that trading sex is associated with increased risk of suicide, and to a lesser extent self-harm, particularly among homeless, runaway, and youth populations (Greene, Ennett, & Ringwalt, 1999; Kidd & Kral, 2002); however, it appears that no research has established a link between work in the bar or entertainment industries, widely defined, and self-directed violence. Subsequent study on this topic might be particularly relevant to transgender persons in Japan, who have few opportunities to acquire “conventional” jobs and are typically relegated to the entertainment, bar, or sex industries (*mizu-shoubai*) due to discrimination in employment based on their perceived difference from “normal” people (DiStefano, 2005; McLelland, 2004).

Cutting, usually of the wrist and arms, was the most commonly reported form of nonfatal self-harm in this study. This finding parallels a focus on cutting in the Japanese literature on self-harm, which typically uses clinical samples in which sexual identity is not reported (e.g., Matsumoto et al., 2004). Participants explained that cutting was used to cope with and override psychological pain associated with being a sexual minority in a stigmatizing environment. This resonates with Matsumoto et al.’s (2004) suggestion that self-harm among some Japanese cutters is a coping mechanism characterized as “analgesic” (Matsumoto et al., 2005), a concept that has been demonstrated also in cutters outside Japan (Bohus et al., 2000).

Despite various forms of injury associated with SMSS, reporting of violent thoughts and behaviors and seeking professional help appear to be rare. Participants commonly explained that Japan’s physicians and mental health providers were mostly very conservative, particularly with regard to gender and sexuality. This discourages help seeking among sexual minorities and makes many clinical encounters, when they do occur, uncomfortable and ineffective. Dealing with homophobia and transphobia by providers is a challenge faced by sexual minorities in other countries, including the United States (Willging, Salvador, & Kano, 2006; Williams, Wyatt, Resell, Peterson, & Asuan-O’Brien, 2004). Future comparative research involving Japanese sexual minorities would do well to examine whether the conservatism they face in health care is more or less of a barrier to accessing appropriate services compared to sexual minorities in other countries.

The findings in this study suggest that intervention strategies regarding SMSS in Japan should address

multiple levels of the social ecology, including cultural homophobia and transphobia; structural institutions that reflect this prejudice and do not fulfill their roles in adequately serving and protecting sexual minority community members; and individual-level perceptions and mental health, which are the most proximal factors influencing suicidal and self-harm behaviors. Subsequent to a more complete understanding of SMSS in Japan, community-based participatory research methods should be applied to seek community consensus on the most appropriate intervention strategies to use in the different sexual minority communities throughout the country.

A potential limitation of this study is that data analyses were conducted by one person: the author. It is possible that the input of additional coders would have served as a check on the accuracy of reported themes. However, the use of a single coder might also have helped to avoid challenges often introduced into analysis with the use of multiple coders on a single data set, including borderline classifications of codes and inconsistency in coding (Manderson, Kelaher, & Woelz-Stirling, 2001).

In sum, this study documents a strong consensus among participants that suicidality and nonsuicidal, often habitual, self-harm behaviors are serious problems among sexual minorities in Japan. Whereas several of the study’s results resonate with those of research in other countries, a number of findings might be unique to Japan: first, the tension between a history of cultural acceptance of suicidality as a morally rational act and the tendency among participants in this study instead to view SMSS as connected to poor mental health; second, the burden of caring for the elderly in Japan’s rapidly aging population as a potential risk factor for SMSS; third, the link between work in the bar or entertainment industries and self-directed violence; and fourth, the very specific economic profile of Japan’s prolonged recession and its apparent influence on suicidality in both the general population and among sexual minorities. Immediate next steps in understanding SMSS in Japan should include (1) additional qualitative studies to examine specific processes and sexual minority subgroups in greater depth and (2) an epidemiologic assessment of SMSS using a large, population-based probability sample of sexual minorities that would (a) estimate the prevalence of SMSS in the population and (b) test hypotheses generated from the baseline findings of the present study. It is hoped this study’s findings can make a

contribution toward the development of culturally appropriate approaches to addressing SMSS in Japan.

## Notes

1. Suicidality refers here to the full spectrum from suicidal ideation to suicide attempts and fatal suicides.
2. Twenty is the age of majority (i.e., adulthood, voting) in Japan.
3. Intersex persons are defined as individuals for whom chromosomal sex is inconsistent with phenotypic sex, or for whom the phenotype is not classifiable as either male or female (Sax, 2002).

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